Title: Selection into Mental Health Court: Distinguishing Among Eligible Defendants

Authors:

Mary Lee Luskin, PhD ab

Bradley Ray, PhD c

a Corresponding author

b Indiana University

Department of Criminal Justice

Bloomington, IN 47405

E-mail: luskin@indiana.edu

c Indiana University – Purdue University Indianapolis

School of Public & Environmental Affairs

Indianapolis, IN 46202

Email: bradray@iupui.edu

The data on which this article are based were provided to the senior author by Policy Research Associates, Delmar, New York.

Luskin, M. L., & Ray, B. (2015). Selection Into Mental Health Court Distinguishing Among Eligible Defendants. Criminal Justice and Behavior, 42(11), 1145-1158. http://dx.doi.org/10.1177/0093854815601158

Abstract

How defendants are selected into mental health courts (MHC) is central to issues of fairness, efficacy, and successful program replication. Only recently has empirical research started to examine MHC selection, revealing a multi-stage process, with multiple decision-makers, and multiple variables (Wolff, Fabrikant, & Belenko, 2011). In this study we use classification and regression tree analysis (CART) to examine the variables suggested by Wolff and colleagues to predict selection into MHC. The analysis includes legal and diagnostic variables, treatment history, measures of treatability, motivation to change, violence risk, and symptom severity. We find that the MHC is more likely to accept defendants who did not have warrants issued for their arrest, who had diagnoses other than depression, and who were not using illegal drugs around the time of their admission. Symptom severity and motivation to treatment also predict MHC admission, with their effects contingent on defendants' statuses on other variables.

Selection into Mental Health Court: Distinguishing Eligible Defendants

Research consistently finds that persons with a serious mental illness are overrepresented in jails (Abram, Teplin, & McClelland, 2003; Kubiak, Beeble, & Bybee, 2010; Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, Abram, & McClelland, 1996; Trestman, Ford, Zhang, & Wiesbrock, 2007) and that these individuals are more likely to continually cycle through the criminal justice system (Porporino & Motiuk, 1995; Travis & Visher, 2005). To address this disparity local jurisdictions have implemented various programs which aim to divert these offenders out of jail or prison and into treatments and services (Steadman & Naples, 2005). One such program is the mental health court (MHC).

Like other specialty courts (e.g., drug treatment courts) the MHC attempts to link defendants into community-based treatments and services to curtail future involvement in the criminal justice system (Goodale, Callahan, & Steadman, 2013). Defendants are referred to MHC by an attorney, the court, police officers, or family members and might also be identified as eligible through jail screening (Almquist & Dodd, 2009). Participation in the court is voluntary, so defendants can choose not to opt in or to opt out at any time, at which point the case is sent back to traditional court for adjudication, (but see Redlich, 2005 and Redlich et al., 2010, on the meaning of “voluntary” in MHC enrollment, and Szmukler and Appelbaum, 2008; Lamberti et al., 2014; Lamberti, 2007; and Redlich, Steadman, Robbins, et al. 2006 on the use of legal leverage for mental health treatment more generally). If the defendant decides to enroll, the MHC team, which is made up of criminal justice and mental health personnel, helps link the defendant to community-based treatments and services; the defendant is then required to attend regularly scheduled status hearings where the team evaluates her or his compliance. If the defendant remains compliant for an allotted period of time, the criminal charges are dismissed or

the sentence is reduced; however, if consistently noncompliant, the defendant is terminated from the process, and the charges are sent back to traditional court.

MHCs have quickly become a standard part of criminal justice policy, with discussions moving from MHCs as a new and interesting response to the over-representation of persons with mental illness in the criminal justice system (Petrila, Poythress, McGaha, & Boothroyd, 2001) to the development of standards and guidelines for establishing MHCs (Council of State Governments Justice Center, 2008; Watson, Hanrahan, Luchins, & Lurigio, 2001). Nonetheless, since the first appearance of MHCs, observers have raised concerns about how defendants are selected for diversion into these courts (Wolff, 2002). MHCs have limited space to accept defendants relative to the number of persons who might be formally eligible. Decisions about which defendants are recommended to and accepted into MHC are based on the discretion of the team members, and very little research has examined this process. Understanding how this discretion is used to select defendants is central to questions of selection bias in outcomes (Wolff, Fabrikant, & Belenko, 2011), judicial fairness (Draine, Wilson, & Pogorzelski, 2008; Erickson, Campbell, & Lamberti, 2006; Seltzer, 2005; Wolff, 2002), and successful program replication (Wolff et al., 2011).

The present study attempts to further our understanding of the selection process with data from one site of the MacArthur Mental Health Court Study, which is one of the few studies that has employed a quasi-experimental design with a treatment-as-usual comparison group (TAU) (Callahan, Steadman, Tillman, & Vesselinov, 2013; Redlich & Han, 2014; Redlich et al., 2010; Steadman, et al., 2011; Steadman, et al., 2014) Using a model of the decision process developed by Wolff et al. (2011) as the guiding framework, we apply classification tree analysis to determine which factors predict whether defendants will end up in the MHC.

Mental Health Court Research

The proliferation of MHCs has occurred alongside a growing number of studies suggesting these courts can be successful in reducing criminal recidivism (Burns, Hiday, & Ray, 2013; Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005; Dirks-Linhorst & Linhorst, 2012; Frailing, 2010; Herinckx, Swart, Ama, Dolezal, & King, 2005; Hiday & Ray, 2010; Hiday, Wales, & Ray, 2013; McNiel & Binder, 2007; Moore & Hiday, 2006; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011); however, the vast majority of these studies have looked at outcomes of a year or less. One of the methodological weakness and limitations commonly noted among these studies is the lack of random assignment; that is, defendants are not randomly admitted into the MHC process. Instead the selection of defendants into MHC is based on a complex decision-making process that can involve several agencies representing the MHC team.

Despite the potential selection bias associated with acceptance into MHCs, little empirical research has been given to this issue. Indeed, empirical studies of selection and referral into MHCs can be counted on one hand (Frailing, 2011; Luskin, 2001; Steadman, Redlich, Griffin, Petrila, & Monahan, 2005). The earliest study was Luskin's (2001) analysis of cases referred to the PAIR MHC in Marion County, Indiana. Using a logistic regression model that included measures of race, gender, age, referral source, criminal history, and type and seriousness of current criminal charges, Luskin found that having a felony history, being male, and being charged with a crime against a person decreased a defendant's chances of being accepted into the court (2001). In addition, age and gender interacted with the result that younger female defendants were more likely than older females to be admitted into the MHC.

While Luskin (2001) looked at the decision to accept defendants into MHC after they had been referred, Steadman and colleagues (2005) analyzed both referrals and acceptance into

MHCs across seven different courts over a three-month period. They found that the parties making the referrals were generally similar across courts (i.e., public defenders and judges) and that there were commonalties in who was referred. Despite the MHCs varying widely with respect to ethnicity, Steadman and colleagues found that compared to the population of national jail and prison inmates, the defendants referred to MHC were more likely to be older white women (Steadman et al., 2005). Overall, about half of those persons referred to these MHCs were accepted, and in general, there were no significant differences in demographics and crime type in a defendant's chances of being accepted. However, severity of mental illness was positively associated with the decision to accept a defendant.

Finally, Frailing (2011) studied acceptance into MHC for defendants referred over a three year period. She found that about half of those referred to MHC were accepted and that the defendants who were accepted into MHC differed significantly from those who were not accepted. Specifically, being male, being charged with a crime against the person, and being charged with a crime against the community decreased the odds of being accepted into the court, whereas a diagnosis of a thought, mood, or anxiety disorder, and a diagnosis of mental retardation, increased the odds. Frailing (2011) also examined the reasons the MHC team gave for rejecting cases and found the reason most often given for rejection was that the case had received an alternative disposition (e.g. sentence to time served, prison sentence, or transfer to drug court (p.317)).

The results from these studies have not been consistent in terms of finding who is referred or accepted into the MHC. Such inconsistencies are to be expected given the relative youth of MHCs, the variability in their structure and operation, and the lack of research and theorizing about how the selection processes work. Moreover, these studies illustrate that there is

more than one point of entry into the MHC process (i.e., referral and admittance). Recent qualitative research by Wolff, Fabrikant, and Belenko (2011) has taken a step towards outlining the stages of the selection process and has provided a theoretical underpinning to help resolve these inconsistencies and guide future research. Wolff and colleagues use document reviews and interviews with key informants across six MHCs to "deconstruct" the courts' selection processes. In doing so they map out three general stages in which defendants are screened and describe a filtering process whereby legal and mental health decisions makers select defendants for the court or exclude them from it (2011, p. 404).

The first stage in the selection process described by Wolff and colleagues (2011) is the *initial screening*. Here defendants with a mental illness are determined as eligible but are filtered out by either the district attorney or MHC team coordinator. At this stage, cases may be screened with respect to whether the charges in the target arrest are eligible and whether there is adequate evidence of a mental illness. The second stage is *assessment eligibility screening* in which defendants undergo a more in-depth review by the MHC team. The defendants have been referred to MHC and meet the eligibility criteria, but at this stage the MHC team examines how the defendant's behavioral health problems are linked to criminal issues. For example, while MHCs have formal diagnostic criteria for eligibility, it is at stage two that team members consider other factors such as co-occurring substance abuse disorders, personality disorders, and past treatment history. The defendant's current criminal status and criminal history are also examined more closely during stage two to look for past violence or outstanding charges. The final stage is *evaluation eligibility screening* which involves approval by the MHC judge as well as the defendant's own agreement to participate. For example, a judge might require a first meeting with a potential MHC defendant regardless of the team's decision to admit, and

defendants themselves might refuse participation once they are presented with the requirements of the court.

The model of the selection process developed by Wolff and colleagues (2011) is multivariate and contingent, including mental health, treatability, and legal factors, with decisions made by multiple people at different stages of the selection process. Though their model suggests a number of research questions, one of the first must be whether the variables identified by these informants do predict selection into MHC. While helpful, what the key informants in Wolff and colleagues' study do not tell us is the relative importance of the variables or how they come into play in relation to each other, that is, about interactions. And given the complexity of the decision structure Wolff and colleagues identify, we should expect interactions. Thus the research questions in the present study are: Which factors among those identified by Wolff and colleagues' informants distinguish formally eligible defendants who are in MHC from those who receive regular criminal court processing? And importantly, what interactions exist among the variables affecting the decision?

Methods

Setting

We investigate these questions with data from Marion County, Indiana, site of the MacArthur Mental Health Court Study, a multi-site, prospective study of MHC outcomes (Callahan, Steadman, Tillman, & Vesselinov, 2013; Redlich & Han, 2014; Redlich et al., 2010; Steadman et al., 2011). The Marion County MHC is a large, well-established MHC (Luskin, 2013). Consistent with Wolff and colleagues' (2011) model, selection into this MHC is a multi-stage process with multiple decision makers. To be eligible for participation, defendants must have a primary diagnosis of schizophrenia, bi-polar disorder, or major depression, though they

may also have additional diagnoses. Both misdemeanor and felony charges are accepted. Defendants do not have to plead guilty to enter the court. Court supervision is typically twelve months in length, and successful completion of the program results in the dismissal of criminal charges.

Selection to the Marion County MHC conformed to the general model laid out above, with a legal actor, in this case a public defender, performing Stage 1 screening. This initial eligibility screening took place at an arrest processing center, through which all newly arrested persons in Marion County passed. Although some defendants came to the attention of the MHC via other paths -- e.g., referral to by a private defense attorney or a mental health treatment provider -- the great majority received their initial screening at the arrest processing center.

Stage 2, the MHC-initiated assessment eligibility screening, was a team process and team decision. The Stage 2 screening was organized around a weekly meeting of the MHC team, which included the public defender, prosecutor, MHC coordinator, and mental health treatment providers. Consideration of a case normally proceeded over several weeks as, on the clinical side, formal diagnoses and treatment history were obtained and, on the criminal justice side, criminal history and more detailed information on the circumstances of the offense were assembled. Discussions of a case at the weekly meeting could include such topics as the circumstances of the offense, clinical factors in addition to the formal diagnosis, (e.g., co-occurring disorders) past violence on the defendant's part, victim's attitudes, prosecutor's policies as they might apply to the case, as well as defendant's competency, motivations for treatment, and family support. The decision whether or not to offer MHC participation to a defendant was a team decision reached at the weekly MHC team meeting. Finally, because judges in the Marion County MHC accepted all defendants recommended by the MHC team, the

Stage 3 decision, to participate, was the defendant's alone. The MacArthur Study does not provide data on those opted-out, so the MHC participants in this study include all participants who were accepted into the court and who decided to participate in the MHC process.

Because the defendants in both the TAU and MHC group met the eligibility criteria for the MHC, our analysis primarily addresses Wolff and colleagues' (2011) second stage of selection: assessment eligibility screening. We do not look at differences based on formal eligibility criteria or selection into the court by the judge or the defendants themselves.

Participants

The Marion County MacArthur study data used in this analysis include information on defendants who were accepted into MHC (n = 99) and on a matched treatment-as-usual (TAU) sample (n = 112) made up of recent arrestees in the same jurisdiction who met the MHC's formal eligibility criteria but were never referred to the court for consideration. To create the TAU sample, the MacArthur study researchers identified defendants at the arrest processing center. Their behavioral health eligibility was determined initially from their responses to the arrest processing center's medical screening questions and later confirmed through clinical records (Steadman et al., 2011). Thus both groups were in the criminal justice system during the same time period (January 2006- July 2007). These defendants were matched to MHC defendants on sex, race, age, and criminal charges.

Table 1 displays descriptive statistics for the sample. Average age at MHC entry was 35.06 (SD = 9.40). Less than half (41.7%, n = 211) of the sample are male and nearly two-thirds are white (65.6%, n = 211). Nearly half (45.1%, n = 206) of the sample were diagnosed as bipolar and a quarter (25.7%, n = 206) were diagnosed with severe depression. The number of

arrests since age 15 reported by participants ranged from 1 to 75 with an average of 12.18 (SD = 13.26).

Analytic Procedure

Do the variables reported by the MHC informants in Wolff and colleagues' study (2011) distinguish MHC defendants from formally eligible defendants who received regular criminal justice processing instead? To address this question, we employ a statistical methodology that has not been utilized in this body of literature: classification and regression tree analysis (CART). CART is a data driven statistical technique that is used to mine variables to create a model that will predict an outcome of interest. It is useful when, as in the case here, there are hypothesized to be many predictor variables that interact in complex ways and when, as is also the case here, exactly which predictor variables interact and in what ways is not well understood. Thus, for example, while defendants with the least severe symptoms might be seen as not needing MHC and therefore excluded, defendants with the highest levels of symptoms might be seen as too sick for the court and also excluded. Moreover, CART does not require or assume a linear relationship between the dependent and independent variables.

We employ the CART algorithm from the R statistical package to generate a classification tree predicting MHC or TAU membership using the variables listed in Table 1. The full tree produced by the algorithm had 44 splits. This full tree classifies every defendant correctly, but it does so by modeling not only real differences, but also noise in the data, that is, the idiosyncrasies of the particular sample. Thus the second stage of the CART analysis must be to prune back the classification tree to a more reliable model of the true predictors of MHC or TAU. A standard criterion for pruning is to choose a tree that minimizes the cross-validated relative prediction error (Breiman et al., 1984). For these data, the minimum cross-validated

relative error is reached at eight splits (xerror = 0.60); however, this minimum is not statistically different from the value for cross-validated relative error produced by only six splits (xerror = 0.63). Thus we present the simpler pruned tree with six splits and seven terminal nodes.

Measures

The MacArthur study includes a wide range of clinical, criminal justice, and treatment-related variables that the work of Wolff and colleagues identify as important to the decision to admit to MHC. The clinical variables we include are the defendant's primary mental health diagnosis obtained from clinical records, psychiatric symptoms as measured by the Colorado Symptoms Index – CSI (Conrad et al., 2001) and responses to the Insight and Treatment Attitudes Questionnaire – ITAQ (McEvoy et al., 1989) measured in the MacArthur study's baseline interview.

The criminal justice variables we include are whether or not the defendant had a warrant issued, obtained from criminal justice records, and the number of arrests since age 15, which was self-reported in the baseline interview. As Table 1 shows, 24.2% (n = 211) of the sample had a warrant issued. Because older defendants will have had more opportunity to accumulate arrests, we measure the rate of arrests defined as the number of arrests since age 15 divided by age.

We include several measures of treatability and suitability. Treatment stability was operationalized as the number of different outpatient facilities at which the defendant reported having received treatment in the previous six months. This variable was constructed from a series of questions in the interview that asked defendants to name up to eight different providers from which the defendant had received treatment in the previous six months; most of the sample had been to one outpatient facility in the previous six months (see Table 1). We also include self-reported violent behavior in the last six months and illegal drug use in the two months prior

to the interview, factor scores for internal and external motivation for treatment (Deci & Ryan, 1985), and self-reported homelessness at any time during the six months prior to the baseline interview. The homelessness variable is included as an indicator of the match between defendants' needs and available resources. Although about 15% (n = 211) of the sample reported having been homeless at some time during the six months prior to baseline interview, previous research found that housing services were rarely provided to defendants in the MHC (Luskin, 2013). Finally, because the two samples were matched on age, race, sex, and criminal charges, we control for these differences and examine what other factors MHC teams find important when determining a defendant's suitability for MHC.

Results

Figure 1 shows the final, pruned classification tree. The ovals represent the intermediate nodes in the analysis, that is, classifications that can be further split, and the rectangles represent the terminal nodes, that is, classes for which the gain in accuracy from a further split is not warranted by the additional complexity added. Each node is labeled with the predicted class (MHC or TAU) for cases with the particular set of characteristics leading to that node and the numbers of cases with those characteristics in the MHC and TAU groups, respectively. Thus the oval at the top of the figure shows the full sample of 211 cases of which 99 are in MHC and 112 in TAU. Because there are more TAU cases than MHC cases in the full sample, the predicted class for any case is TAU, with a predicted probability of 0.53 (112/(99 + 112) = 0.53).

As can be seen in Figure 1, the variables used to classify these data are whether a warrant was issued, diagnosis, self-reported drug use, CSI, and internal motivation scores. The variables that did not improve the cross-validated predicted classification (with the complexity parameter

set at 0.025) were the number of prior arrests, self-reported violence, number of outpatient facilities, external motivation, insight scores, and homelessness.

The first variable on which the data are split is whether a warrant was issued. This is the single variable that best splits the data into two groups. For all defendants with warrants, except for the very few defendants with the very low symptom scores (CSI < 8.03), the predicted class is TAU, with a predicted probability of 0.96 (Pr TAU = 46/(46+2) = 0.96) and, conversely, a predicted probability of only 0.04 of being in the MHC (Pr = 1 – Pr TAU)). Nearly all defendants with warrants were in the TAU rather than the MHC group.

The picture for defendants who do not have warrants is more complicated. Among defendants without warrants who also have diagnoses of depression, the predicted class is TAU, with a predicted probability of 0.74 for being in the TAU group (estimated predicted probability TAU = 25/(25+9) = 0.74) and a predicted probability of 0.26 of being in the MHC. Defendants without warrants whose diagnosis is something other than depression, that is, who have a diagnosis of either schizophrenia or bi-polar disorder, and who did not report having used illegal drugs are predicted to be in MHC with a probability of 0.81 (estimated predicted probability MHC = 56/(56+13) = 0.81; estimated predicted probability of TAU = 1 - 0.81 = 0.19). For defendants without warrants and diagnoses other than depression but who did use illegal drugs, the predicted class further depends on the severity of symptoms reported. Those with CSI scores in the lowest quartile, that is, below 18.61(mean CSI = 25.60), are predicted to be in the MHC, with a predicted probability of 0.92. On the other hand, if their CSI scores were above the 25th percentile, whether they are predicted to be in MHC or TAU depended on their internal motivation to treatment scores. Those whose internal motivation scores were above the mean, (≥ 0.02), are predicted to be in the MHC (predicted probability of 0.57), while those with internal

motivation scores below the mean have a predicted probability of 0.81 of being in the TAU group and only 0.19 of being in MHC.

Overall, the CART analysis suggests that being accepted into MHC is predicted by not having a warrant, having a diagnosis of schizophrenia or bi-polar disorder rather than depression, and not using illegal drugs; however, if using illegal drugs, having lower symptom scores or higher than average internal motivation scores improves the probability of being accepted. On the other hand, being in TAU is predicted by having had a warrant issued, being diagnosed with depression, and drug use with higher than the mean symptom and lower than mean internal motivation to treatment scores.

Discussion

Consistent with Wolff and colleagues' (2011) findings, both criminal justice and treatment related measures predicted who was and who was not in the MHC. TAU defendants were more likely to have warrants, to be diagnosed with depression, to use illegal drugs, to have more serious symptoms and less internal motivation to treatment. MHC defendants were more likely to have diagnoses of schizophrenia or bi-polar disorder, and to report not having used illegal drugs.

Warrants

Whether a warrant was issued is an implicit, informal criterion that separated those formally-eligible defendants who would be considered for the court from those who were not. Although no formal policy excluded defendants with warrants from being considered for the MHC, almost none of the eligible defendants with warrants were in the MHC. The importance of this variable in the classification calls attention to the structure of the decision and the circumstances in which it is made. In this court, initial eligibility screening (Wolff et al., 2011) is

done at an arrest processing center by a public defender. At this initial screening, the public defender must make quick decisions about the allocation of a limited resource, i.e., MHC resources, on the basis of limited information—precisely the conditions under which a perceptual shorthand is likely to develop (Hawkins, 1981; Bridges & Steen, 1998; Albonetti, 1991; Ray & Dollar, 2013). For MHC teams, the presence of an earlier warrant is information that is easily ascertained and relevant to the decision at hand. A warrant can be seen as indicating the defendant's likely success in the MHC as well as her or his deservingness of being there. It also may be used to identify those defendants who pose more of a risk for the MHC. After all, a defendant with a warrant has already failed to appear at court, leading to questions about whether the defendant will be capable of attending monthly status hearings, maintaining treatment appointments, and remaining compliant with court mandates. In addition – and especially to a legal actor – the presence of a warrant may suggest criminality rather than illness and therefore a defendant less worthy of the special treatment available through MHC.

Diagnosis

Defendants diagnosed with depression had a predicted probability of only 0.25 of being in the MHC group. Although major depression is one of three qualifying diagnoses for this MHC, depression seems to have been treated differently from schizophrenia and bi-polar disorder in terms of the selection process. MHC decision makers may think of schizophrenia's delusions as prototypically diminishing legal responsibility, or it may be more difficult to see how depression might contribute to criminal behavior. A more severe diagnosis may strengthen the perception that there is a connection between the client's criminal behavior and mental illness, which Wolff and colleagues (2011) found to be reported as part of the informal eligibility

criteria used by clinicians. Thus the behavior of persons suffering from depression may be regarded as criminal rather than as symptomatic of illness.

Illegal Drug Use

Self-reported illegal drug use comes into play through its interaction with other variables. Although substance use is common among criminal defendants with mental illnesses, substance abuse, nonetheless, presents MHC teams with an alternative explanation of behavior. In addition, defendants who admit to using illegal substances are likely to be seen as higher risk for completing the program. The role that illegal drug use plays in MHC selection likely varies by courts' target populations. For example, illegal drug use may be less important in MHC's whose target population is defendants with a dual diagnoses (i.e., a co-occurring treatment court) compared to courts who exclude those with a substance use disorder (see Steadman et al., 2014). However, it is important to note that the MHC in this study did not limit eligibility based on illegal drug use. Indeed, over a third of those accepted into MHC had self-reported illegal drug use. But as the classification tree in Figure 1 shows, if a potential MHC defendant is using illegal drugs, then selection into MHC further depends on the individual's severity of symptoms and internal motivation to treatment.

Symptom Severity and Motivation

Wolff and colleagues' (2011) findings suggest that MHCs integrate elements of internal and external motivation into the process (e.g. through incentives and sanctions). Hence client motivation is likely to be important in who teams select. We found that symptom scores and internal motivation to treatment made a difference to the classification of defendants who used illegal drugs. Among defendants who used illegal drugs, those who reported the least severe symptoms were in the MHC group. In contrast, defendants whose CSI scores were above the

lowest quartile were in the TAU group, unless they also had higher than average internal motivation to treatment. Severity of symptoms and motivation mitigated the effect of drug use for defendants who would otherwise be rejected. Thus, defendants who might initially look to be poor candidates for MHC may be accepted if they appear treatable because their symptoms are not too bad or because they are internally motivated to change. These results give some credence to the hypothesis that MHC may be skimming defendants, that is, selecting defendants who are easier to treat. Alternatively, given the waiting times between first identification and entry to the MHC (Redlich, Liu, Steadman, Callahan, & Robbins, 2012) the difference in symptom severity between the two groups may be the result not of initial differences in symptoms but of the effects of treatment delivered during the time between initial consideration for MHC and actual entry (Luskin, 2013).

Limitations

Because of the nature of the samples used here, there is the possibility that the observed differences between the MHC and TAU groups are the result not of selection by the MHC, but of sampling. The comparison in this analysis is between defendants matched on criminal charges, gender, race, and age. While there is no reason to expect that any differences between the two groups that resulted from sampling failure should be related to the variables previously identified as relevant to the selection decision, this possibility remains.

The use of data collected for other purposes also means that not every factor named by Wolff and colleagues' (2011) informants could be included in the analysis. The richness of the MacArthur data, however, allowed us to include measures from each of the legal, diagnostic, and treatability categories that Wolff and colleagues' informants named. Most of these measures have not been included in previous studies of MHC selection.

This study is limited also in that it examines selection in only one MHC setting. While the MHC studied has all of the characteristics of an MHC (Almquist & Dodd, 2009), the findings may be unique to this setting. Wolff and colleagues (2011) make the point that, although they can identify broad stages and lists of factors, there is variability across even the six middle sized courts in their sample. Only by analyzing the selection process in other MHCs will research be able to tell whether there are consistent patterns in the factors by which MHC teams select defendants. There is, however, some reason to believe that they might. The variables that distinguished defendants in the MHC and TAU groups in this analysis are a subset of those that Wolff and colleagues' informants reported using. In addition, although previous research on selection is limited, the finding in this analysis that diagnosis, and specifically a diagnosis of depression, was important in distinguishing defendants who were in or not in the MHC is consistent with Steadman and colleagues' (2005) finding that persons with schizophrenia and bi-polar disorder were more likely to be accepted than were other mental illnesses (a category in which they included depression). Moreover, the variables most important to acceptance into MHC had clear relationships to the concerns about criminality, illness, and treatability raised by the informants in Wolff and colleagues' study.

Our analysis, however, cannot address important questions of racial or gender bias. The data we use were matched on race and gender (as well as age and criminal charges). Thus these results can speak only to the question of whether, controlling for race and gender, the selection considerations that MHC team members say inform their decisions do, in practice, distinguish between defendants in and not in MHC.

Conclusion

The premise of MHCs is to bring both legal and clinical considerations into the criminal justice system's responses to persons with mental illness. Our results are consistent with the complex, highly contingent decision implied by Wolff and colleagues' (2011) model and confirm the importance of both legal and treatment-related variables interacting to distinguish those persons selected for the MHC. Overall we find that the variables that distinguish those in the MHC from the formally eligible who were in the TAU group are related to two key questions faced by the MHC team: how likely is a defendant to succeed in the program and to what extent should the defendant be held culpable.

With respect to the question of how likely a person is to succeed, the results suggest some unwillingness on the part of team members to take on the hardest cases. Rather, they suggest that teams are looking for those defendants whom they see as being the best fit for the MHC process. Almost none of the defendants in the MHC had warrants. They were also less likely to be using illegal drugs, or if using illegal drugs, to have fewer symptoms and to be more highly motivated to treatment. The TAU group was a different kettle of fish: These defendants had failed in the past to comply with court orders to appear; they were more likely to be using illegal drugs; their symptoms were more severe; and they showed less internal motivation to treatment.

The impact of a diagnosis of depression, especially, on the classification tree, but also the impacts of illegal substance use and warrants, can be understood through their influence on MHC team members' assessment of the extent to which mental illness contributed to the crime. Though the statute under which this court was established states that the prosecutor can divert cases, "when mental illness contributed to the crime," it does not give guidance as to what factors should be used in making this determination (IC 12-23-5-1). Guides for designing MHCs are equally silent, treating the question of guilt or the extent to which culpability might be

mitigated by mental illness as unproblematic (Johnston, 2012, p.555). Yet such determinations bring us directly to the question of who "deserves" the special treatment of MHC (Draine et al., 2008; Johnston, 2012; Wolff, 2003).

Understanding who is selected for MHC, and why they are selected, is not only important to empirical assessments on the effectiveness of these programs, but perhaps more importantly on the ethical nature of the MHC model and how these programs will operate in the future. In this study the TAU group constitutes a class of defendants with substantial need who were never considered for MHC. It is important to ask whether a MHC team's perception of treatability, culpability, and deservedness is sufficient to determine who is given the opportunity for the limited resources of the MHC. The expertise of clinical personnel is important to informing selection, but in the adversary system, judgment about the impact of mental illness on defendants' culpability is formally allocated to the judge or jury as finders of fact (Landsman, 1983; 1988). In practice many decisions in the adversary system have shifted to the prosecutor; yet in MHCs, this determination devolves further to the MHC team and, depending on the way in which selection process is structured, the decision may be made solely by mental health personnel. Only recently has research attempted to explore the MHC team process and has primarily focused on the understanding the complexities of a non-adversarial decision-making process that involves criminal justice and legal personal (Luskin, 2001; Wolff et al., 2011; Ray & Dollar, 2013). Given the findings in this study, future research might focus explicitly on understanding how MHC personnel process potential risk and how perceived risk differs across team members, defendants, and the variables highlighted in this and other MHC research. In addition, it should explore whether and how MHC teams' use of standardized risk assessment

instruments may alter the significance of socio-demographic, criminal justice, and treatment variables in predicting who is selected into the MHC process.

As MHCs continue to proliferate, it is important to ask when, how, and by whom judgments about selection are made, and whether the mere presence of legal actors on the MHC team is sufficient to uphold a public interest in justice. And a concern for equal justice should put these questions at the center of a principled determination of who should be selected for MHC.

References

Abram, K. M., Teplin, L. A., & McClelland, G. M. (2003). Comorbidity of severe psychiatric disorders and substance use disorders among women in jail. *American Journal of Psychiatry, 160*(5), 1007-1010.

Albonetti, C. A. (1991). An integration of theories to explain judicial discretion. *Social Problems, 38*(2), 247-266.

Almquist, L., & Dodd, E. (2009). *Mental health courts: A guide to research-informed policy and practice.* New York: Council of State Governments Justice Center.

Breiman, L., Friedman, J. H., Olshen, R. A. & Stone, C. J. (1984). *Classification and regression trees*. Monterey, CA: Wadsworth.

Bridges, G.S., & Steen, S. (1998). Racial disparities in official assessments of juvenile offenders: Attributional stereotypes as mediating mechanisms. *American Sociological Review, 63*(4) 554-570.

Burns, P. J., Hiday, V. A., & Ray, B. (2013). Effectiveness 2 years postexit of a recently established mental health court. *American Behavioral Scientist, 57*(2), 189-208.

Callahan, L., Steadman, H. J., Tillman, S., & Vesselinov, R. (2013). A multi-site study of the use of sanctions and incentives in mental health courts. *Law and Human Behavior, 37*(1), 1-9.

Christy, A., Poythress, N. G., Boothroyd, R. A., Petrila, J., & Mehra, S. (2005). Evaluating the efficiency and community safety goals of the Broward County mental health court. *Behavioral Sciences & the Law, 23*(2), 227-243.

Conrad, K. J., Yagelka, J. R., Matters, M. D., Rich, A. R., WIlliams, V., & Buchanan, M. (2001). reliability and validity of a modified Colorado symptom index in a national homeless

sample. *Mental Health Services Research, 3*(3), 141-153.

Council of State Governments Justice Center. (2008). *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court*: New York: Council of State Governments.

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum.

Dirks-Linhorst, P. A., & Linhorst, D. M. (2012). Recidivism outcomes for suburban mental health court defendants. *American Journal of Criminal Justice 37*, 76-91.

Draine, J., Wilson, A. B., & Pogorzelski, W. (2008). Limitations and potential in current research on services for people with mental illness in the criminal justice system. *Journal of Offender Rehabilitation, 45*((3/4)), 157-177.

Erickson, S., Campbell, A., & Lamberti, J. (2006). Variations in mental health courts: Challenges, opportunities, and a call for caution. *Community Mental Health Journal, 42*(4), 335-344.

Frailing, K. (2010). How mental health courts function: Outcomes and observations. *International Journal of Law and Psychiatry, 33*(4), 207-213.

Frailing, K. (2011). Referrals to the Washoe County mental health court. *International Journal of Forensic Mental Health, 10*(4), 314-325.

Goodale, G., Callahan, L., & Steadman, H. J. (2013). What can we say about mental health courts today? *Psychiatric Services, 64*(4), 298-300.

Hawkins, D.F. (1981). Causal attribution and punishment for crime. *Deviant Behavior, 2*(3), 207-230.

Herinckx, H. A., Swart, S. C., Ama, S. M., Dolezal, C. D., & King, S. (2005). Rearrest and

linkage to mental health services among clients of the Clark County mental health court program. *Psychiatric Services, 56*(7), 853-857.

Hiday, V. A., & Ray, B. (2010). Arrests two years after exiting a well-established mental health court. *Psychiatric Services, 61*(5), 463-468.

Hiday, V. A., Wales, H. W., & Ray, B. (2013). Effectiveness of a short-term mental health court: Criminal recidivism one year post-exit. *Law & Human Behavior, 37*(6), 401-411.

Johnston, E. (2012). Theorizing mental health courts. *Washington University Law Review, 89*(3), 519-579.

Landsman, S. (1983). A brief history of the adversary system. *Ohio State Law Journal, 44(3)* 713-742.

Landsman, S. (1988). *Readings on Adversarial Justice*: *The American Approach to Adjudication.* St. Paul, Minnesota: West Publishing Co.

Kubiak, S. P., Beeble, M. L., & Bybee, D. (2010). Testing the validity of the K6 in detecting major depression and PTSD among jailed women. *Criminal Justice and Behavior, 37*(1), 64-80.

Lamberti, J.S. (2007). Understanding and preventing criminal recidivism among adults with psychotic disorders. *Psychiatric Services*, 58(6): 773-781.

Lamberti, J.S., Russ, A., Cerulli, C., Weisman, R.L., Jacobositz, D., and Williams, G.C. (2014). Patient experiences of autonomy and coercion while receiving legal leverage in forensic assertive community treatment. *Harvard Review of Psychiatry* 22(4): 222-230.

Luskin, M. L. (2001). Who is diverted? Case selection for court-monitored mental health treatment. *Law & Policy, 23*(2), 217-236.

Luskin, M. L. (2013). More of the same: Treatment in mental health courts. *Law & Human*

Behavior, 37(4), 255-266.

McEvoy, J. P., Apperson, L. J., Appelbaum, P. S., Ortlip, P., Brecosky, J., Hammill, K., & Roth, L. (1989). Insight in schizophrenia: Its relationship to acute psychopathology. *Journal of Nervous and Mental Disease, 177*(1), 43-47.

McNiel, D. E., & Binder, R. L. (2007). Effectiveness of a mental health court in reducing criminal recidivism and violence. *American Journal of Psychiatry, 164*(9), 1395-1403.

Moore, M. E., & Hiday, V. A. (2006). Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants. *Law and Human Behavior, 30*(6), 659-674.

Petrila, J., Poythress, N., McGaha, A., & Boothroyd, R. (2001). Preliminary observations from an evaluation of the Broward County mental health court. *Court Review*(Winter), 14-22.

Porporino, F. J., & Motiuk, L. L. (1995). The prison careers of mentally disordered offenders. *International Journal of Law and Psychiatry, 18*(1), 29-44.

Ray, B., & Dollar, C.B. (2013). Examining mental health court completion: A focal concerns perspective. *The Sociological Quarterly, 54*(4), 647-699.

Redlich, A.D. (2005). Voluntary but knowing and intelligent? Competence in mental health courts. *Pscychology, Public Policy, and Law,* 11(4), 605.

Redlich, A. D., & Han, W. (2014). Examining the links between therapeutic jurisprudence and mental health court completion. *Law and Human Behavior, 38*(2), 109-118.

Redlich, A.D., Hoover, S., Summers, A., & Steadman, H.J. (2010). Enrollment in mental health courts: Voluntariness, knowingness, and adjudicative competence. *Law & Human Behavior* 34(2): 91-104.

Redlich, A. D., Liu, S. Y., Steadman, H. J., Callahan, L., & Robbins, P. C. (2012). Is diversion

swift? Comparing mental health court and traditional criminal justice processing. *Criminal Justice and Behavior, 39*(4), 420-433.

Redlich, A.D., Steadman, H.J., Robbins, P.C., & Swanson, J.W. (2006). Use of the criminal justice system to leverage mental health treatment: Effects on treatment adherence and satisfaction. *Psychiatry and the Law Online* 34(3): 292-299.

Redlich, A. D., Steadman, H. J., Callahan, L., Robbins, P. C., Vessilinov, R., & Ozdogru, A. A. (2010). The use of mental health court appearances in supervision. *International Journal of Law and Psychiatry, 33*(4), 272-277.

Seltzer, T. (2005). Mental health courts: A misguided attempt to address the criminal justice system's unfair treatment of people with a mental illness. *Pscyhology, Public Policy, and Law, 11*(4), 570-586.

Steadman, H. J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behavioral Sciences & the Law, 23*(2), 163-170.

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*(6), 761-765.

Steadman, H. J., Redlich, A., Callahan, L., Robbins, P. C., & Vesselinov, R. (2011). Effect of mental health courts on arrests and jail days a multisite study. *Archives of General Psychiatry, 68*(2), 167-172.

Steadamn H. J., Callahan L., Robbins P.C., Vesselinov, R., McGuire, T. G., & Morrissey, J. P. (2014). Criminal justice and behavioral health care costs of mental health court participants: A six-year study. *Psychiatric Services, 65*(9), 1100-1104.

Steadman, H. J., Redlich, A. D., Griffin, P., Petrila, J., & Monahan, J. (2005). From referral to

disposition: Case processing in seven mental health courts. *Behavioral Sciences & the Law, 23*(2), 215-226.

Szmukler, G.& Appelbaum, P.S. (2008) Treatment pressures, leverage, coercion, and compulsion in mental health care. *Journal of Mental Health* 17(3): 233-244.

Teplin, L. A., Abram, K. M., & McClelland, G. M. (1996). Prevalence of psychiatric disorders among incarcerated women: I. Pretrial jail detainees. *Archives of General Psychiatry, 53*(6), 505-512.

Travis, J., & Visher, C. A. (2005). *Prisoner reentry and crime in America*. Cambridge ; New York: Cambridge University Press.

Trestman, R. L., Ford, J., Zhang, W., & Wiesbrock, V. (2007). Current and lifetime psychiatric illness among inmates not identified as acutely mentally ill at intake in Connecticut's jails. *Journal of the American Academy of Psychiatry and the Law, 35*(4), 490-500.

Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A. (2001). Mental health courts and the complex issue of mentally Ill offenders. *Psychiatric Services, 52*(4), 477-481.

Wolff, N. (2002). Courts as therapeutic agents: Thinking past the novelty of mental health courts. *Journal of the American Academy of Psychiatry and the Law, 30*(3), 431-437.

Wolff, N. (2003). Courting the court: Courts as agents for treatment and justice. *Research in Community and Mental Health, 12*, 143-198.

Wolff, N., Fabrikant, N., & Belenko, S. (2011). Mental health courts and their selection processes: Modeling variation for consistency. *Law and Human Behavior, 35*(5), 402-412.

Table 1: Descriptive Statistics for the Variables Included the Classification Models

Variable	*N*	*Minimum/ Maximum*	*Mean*	*SD*
Age	211	18/57	35.06	9.40
Gender (Male = 1; Female = 0)	211	0/1	41.70	—
Race (White = 1; Otherwise = 0)	209	0/1	65.60	—
Bipolar Diagnosis (Yes = 1; No = 0)	206	0/1	45.10	—
Depression Diagnosis (Yes = 1; No = 0)	206	0/1	25.70	—
Colorado Symptom Index Total Score (CSI)	211	0/51	26.59	11.84
Insight/ITAQ Score	203	2/22	19.06	3.17
Warrant Issued (Yes = 1; Otherwise = 0)	211	0/1	24.20	—
Number of Arrests Since Age 15	207	1/75	12.18	13.26
Number of Different Outpatient Facilities	211	0/3	1.07	0.55
Violence Score[a]	204	-2.10/1.70	—	—
Illegal Drugs in Previous 6 Months (Yes = 1; No = 0)	209	0/1	50.70	—
Internal Treatment Motivation Score[a]	204	-1.51/2.14	—	—
External Treatment Motivation Score[a]	204	-1.50/3.00	—	—
Homeless in Previous 6 Months (Yes = 1; No = 0)	211	0/1	17.50	—

[a]Scores are factored

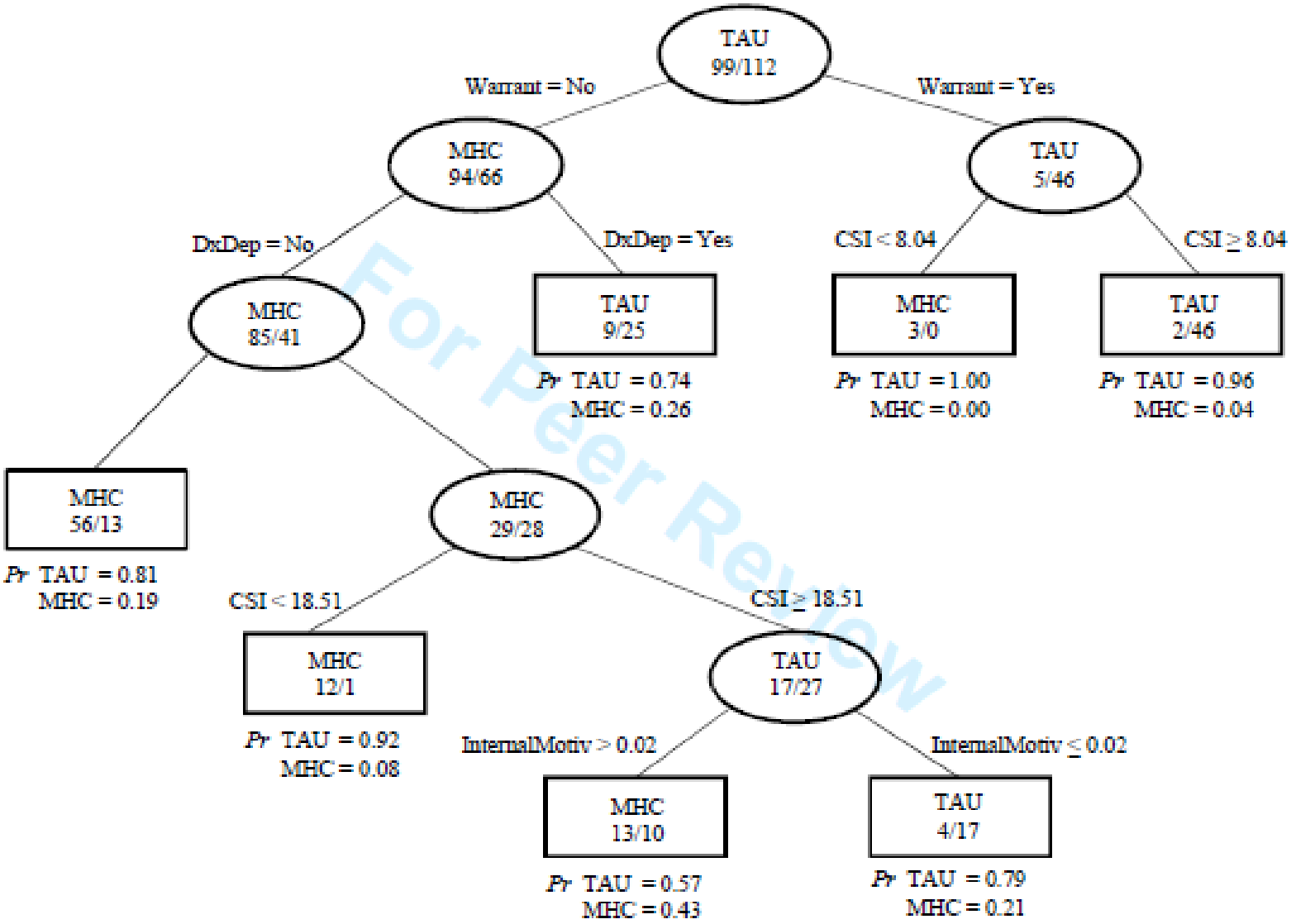

Figure 1: Predicted Probabilities of MHC and TAU Group Membership